Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2190HHA	A. BUILDING _____ B. WING _____	C 01/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUALITY NURSING LLC	801 S RANCHO #C2 LAS VEGAS, NV 89102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 00	INITIAL COMMENTS Surveyor: 27286 This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on January 28, 2010 in accordance with Nevada Administrative Code, Chapter 449, Home Health Agencies. Complaint #NV00022743 was unsubstantiated with an unrelated deficiency cited. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiency was identified:	H 00		
H200 SS=A	449.800 Medical Orders 8. New orders are required when there is a change in orders, a change of physician or following hospitalization. This Regulation is not met as evidenced by: Surveyor: 27286 Based on clinical record review, the agency failed to obtain new orders for changes made to the plan of care for 1 of 1 patient. Severity: 1 Scope: 1	H200		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE